

Intentional Unprotected Anal Intercourse among Sex Who have Sex with Men: Barebacking—from Behavior to Identity

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Abstract Unprotected sex among gay/bisexual men throughout the AIDS epidemic has usually been described as unintentional due to a relapse from safer sex behavior. The term “barebacking” emerged among HIV-positive men explicitly seeking unprotected sex with seroconcordant partners, but has come into use in the larger gay community to simply mean condomless sex. Some men have also taken on the identity as a “barebacker.” The present study assessed prevalence and predictors of bareback identity in a sample 687 gay/bisexual men attending community events. Barebackers reported significantly more use of crystal methamphetamine and higher peer norms for unprotected sex; HIV-negative barebackers were higher in sexual compulsivity while HIV-positive barebackers were higher in romantic obsession as well as drug/alcohol influenced sexual expectancies. HIV prevention efforts targeting barebackers and barebacking must be carefully developed if programs and campaigns are to be effective given the open debates about this phenomenon in the gay community.

Keywords Bareback · Identity · Sexual compulsivity · Substance use · Peer norms

Introduction

Before the advent of HIV, the hepatitis B outbreaks in gay urban centers in the 1970s (Doll et al., 1990) sparked empirical investigations into the sexual behaviors of gay and bisexual men. With the emergence of HIV, the identification of the complex contextual factors related to unprotected anal sex among gay and bisexual men in the face of such a threat became paramount. In some research studies, factors such as sexual behavior and sexual expectations while under the influence of alcohol and drugs (Halkitis, Parsons, & Stirratt, 2001; Irwin, Morgenstern, Parsons, Wainberg, & Labouvie, in press; McKirnan, Ostrow, & Hope, 1996; Parsons et al., 2004; Purcell, Moss, Remien, Woods, & Parsons, 2005; Purcell, Parsons, Halkitis, Mizuno, & Woods, 2001), the use of the Internet (Wolitski, 2005), and utilization of sexually charged venues for locating potential sexual partners (Parsons, 2005a; Parsons & Vicioso, 2005; Wolitski, 2005) have been identified as contributing to unprotected sex. Individual factors have also received much attention: compulsive sexual behaviors (Benotsch, Kalichman, & Kelly, 1999; Muench & Parsons, 2004), safer sex fatigue (Adam, Husbands, Murray, & Maxwell, 2005; Wolitski, 2005), and unprotected sex as a reflection of the values of individual choice and individual responsibility on which western cultures are based (Adam, 2005). Much of this research has been based on the assumption that individuals want to avoid unprotected sex with significant findings viewed as targets for intervention.

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Prior to 1997, sex without condoms among gay and bisexual men was mostly described by researchers as unintentional, some had unprotected sex randomly or inconsistently, others experienced a relapse from safer sex behaviors (Adam, 2005; Adib, Joseph, Ostrow, & James, 1991a; Adib, Joseph, Ostrow, Tal, & Schwartz, 1991b; Adib & Ostrow, 1991, 1995; Ekstrand, 1992; Roffman et al., 1998; Williams, Elwood, & Bowen, 2000; Wolitski, 2005). While unprotected sex as a result of relapse or situations in which men intended to use condoms initially but then failed to do so continues, these “unintentional” unprotected sex behaviors should be differentiated from the increasingly common “intentional” practice of *barebacking* (unprotected anal sex); (Goodroad, Kirksey, & Butensky, 2000; Parsons, 2005a; Wolitski, 2005). However, many have argued that there has always been a sub-group of high risk taking individuals throughout the HIV epidemic (Boily, Godin, Hogben, Sherr, & Bastos, 2005; Colfax et al., 2002; HIV/AIDS Surveillance Project Group, 2004; Robins, Dew, Kingsley, & Becker, 1997; Schonnesson & Clement, 1995; Tawk, Simpson, & Mindel, 2004). Finally, barebacking must be differentiated from negotiated safety in which two HIV-negative partners decide to forgo condoms after consistent condom use and repeated HIV testing (Kippax, 2002).

The term barebacking first emerged in 1997 in a publication for HIV-positive persons (Gendin, 1997; Strub, 1997). Two years later this same publication (Gendin, 1999) published an article “They shoot barebackers, don’t they?” suggesting that this behavior had become a personal attribute and perhaps an identity among HIV positive gay and bisexual men as well. In the time since, the term barebacking appears to have supplanted the awkward phrases “sex without condoms” and “condomless sex” in the gay community as a whole (Morin et al., 2003; Halkitis, Parsons, & Wilton, 2003; Huebner, Proescholdbell, & Nemeroff, 2004), without any intentionality implied. A concrete example is in the most recent edition of *The Joy of Gay Sex* (Silverstein & Picano, 2003) that included an entry on barebacking and defines the term simply as unprotected anal sex. Regardless, barebacking has become a vague term, many times referring to any kind of unprotected sex, but often still retains a sense of intentional condomless sex (Adam et al., 2005, p. 244).

Published studies of barebacking behavior among gay and bisexual men have often included intention as part of the definition of barebacking (Gauthier & Forsyth, 1999). Quantitative surveys, interviews and ethnography (Bimbi & Parsons, 2005; Carballo-Diequez, 2001; Carballo-Diequez & Bauermeister, 2004; Davis, 2002; Gauthier & Forsyth, 1999; Grov,

2004; Halkitis & Parsons, 2003; Halkitis et al., 2003, 2005; Holmes & Warner, 2005; Mansergh et al., 2002; Morin et al., 2003; Ridge, 2004) have been employed to understand this phenomenon. Examination of the discourses in Internet venues (e.g., websites, chatrooms, electronic bulletin boards, etc.) devoted to barebacking has identified several themes (or reasons) gay and bisexual men have for barebacking, such as increased sensation and barebacking as erotic risk-taking (Carballo-Diegues & Bauermeister, 2004; Gauthier & Forsyth, 1999). Sexual adventurism differentiated men who engaged in barebacking from those who did not in a sample of urban gay and bisexual HIV positive men (Halkitis & Parsons, 2003). Halkitis et al. (2005) found, among their sample of HIV-positive gay and bisexual men, that sexual compulsivity, methamphetamine use, and sex under the influence of drugs were predictive of identification as a barebacker among the 27.2% of men who identified as such.

Other researchers, however, have referred to gay and bisexual men who report intentional anal sex without condoms as “barebackers” (Adam, 2005; Carballo-Diequez, 2001; Gauthier & Forsyth, 1999; Halkitis et al., 2003; Junge, 2002) without ascertaining if their participants identified as such; ipso facto one is a barebacker if one reports sex without condoms. For example, Mansergh et al. (2002) reported that 22% of HIV positive men and 10% of HIV negative men in their sample intentionally had unprotected sex within the last 2 years. Halkitis et al. (2003) reported markedly different rates of 61 and 42%, respectively, in the last three months, but for unprotected sex of any kind, intentional or otherwise. Lastly, barebacker as an identity among HIV-negative gay and bisexual men is an unexplored area.

The purpose of the present study was to assess the prevalence of gay and bisexual men (both HIV positive and HIV negative) identifying *themselves* as barebackers and to determine factors related to having a barebacker identity. Based on the previous research on sexual risk taking and barebacking (Halkitis et al., 2005; Mansergh et al., 2002), it was hypothesized that HIV positive men would be more likely identify as a barebacker and that use of crystal methamphetamine, sexual compulsivity, peer norms, and sexual expectations while under the influence of alcohol and drugs would be related to a bareback identity.

Method

Participants and Procedure

Men ($N = 1072$) attending one of two large lesbian, gay, bisexual, and transgendered (LGBT) community

events (the Gay Life Expo and the Gay Erotic Expo) in New York City during the fall of 2002, completed a brief paper and pencil survey which took approximately 10–15 min to complete. Entrance to the event required paid admission, however, discount passes were widely available and free admission passes were provided to gay/lesbian and HIV related community organizations. Individuals attending the event were approached and invited to complete the “Sex and Love Survey” by a member of the research team. Those who agreed to participate were given a survey on a clipboard and a pencil, and were encouraged to move to nearby seating areas for privacy. The first page of the survey served as the assent form. The response rate was high, with approximately 83.8% of individuals approached consenting to participate. A movie pass was given as an incentive for completing the survey.

A total of 268 men reported sex with only one male partner in a monogamous relationship, resulting in a sample of 804 sexually active single or non-monogamous men who have sex with men. A total of 40 men failed to provide responses to the question regarding barebacking identity, 19 men refused to report their HIV status, and another 58 men reported not knowing their HIV status resulting in a final sample for analyses of 687 men. With the exception of the substance use variables, missing data was minimal and less than 5% for all other variables analyzed and presented herein. Missing data analyses revealed no systematic bias in refusal to answer the questions regarding the use of individual substances with sex.

The sample reported an average age of 36.2, range 18–80, $SD = 10.17$. White men accounted for the majority of the sample (65.6%, $n = 451$) followed by Latino (11.2%, $n = 77$), African-American (8.7%, $n = 60$), Asian/Pacific Islander (7.4%, $n = 51$) and the remainder were of “other” or mixed race/ethnicity (7.1%, $n = 48$). No racial differences in prevalence of bareback identity or substance use were observed.

The majority of the men self reported being HIV negative (86.6%, $n = 595$) and 13.4% reported being HIV positive ($n = 92$). HIV negative men were significantly younger, 35.76 vs. 38.77, $F(1, 685) = 7.04$, $P < .01$. Racial/ethnic groups also significantly differed in self reported HIV status, $\chi^2(4, N = 687) = 40.10$, $P < .01$. Post hoc analyses revealed that African American men were more likely to be HIV positive, 36.7% ($n = 22$), compared to White men, 9.3% ($n = 42$), $\chi^2(1, N = 511) = 36.17$, $OR = 5.65$, 95% $CI: 3.05, 10.42$; compared to Asian/Pacific Islander men, 9.8% ($n = 5$), $\chi^2(1, N = 111) = 10.81$, $OR = 5.32$, 95% $CI: 1.84, 15.38$, and compared to men of mixed race or “other,” 12.5% ($n = 6$), $\chi^2(1, N = 108) = 8.11$, $OR = 4.05$, 95% $CI: 1.49,$

11.11. Latino men were only more likely to be HIV positive, 22.1% ($n = 17$), compared to White men, 9.3% ($n = 42$), $\chi^2(1, N = 528) = 10.80$, $OR = 2.76$, 95% $CI: 1.48, 5.16$.

Measures

Demographics

The demographic characteristics of respondents were assessed using fill-in-the-blank measures of age, a race/ethnicity checklist, an HIV status checklist (positive, negative, don’t know/untested, refuse to answer), and a sexual orientation checklist (gay, bisexual, heterosexual, or refuse to answer).

Bareback Identity

Participants were asked to indicate *yes* or *no* to the question “I consider myself a barebacker” after completing a likert type agreement scale (1 = *strongly disagree* to 5 = *strongly agree*) to assess intentions for barebacking (defined as sex without condoms) by sexual position (anal insertive or anal receptive). Detailed analyses of the intention items have previously been reported elsewhere (Bimbi & Parsons, 2004).

Sexual Behaviors

Participants were asked to indicate *yes* or *no* if they had engaged in four anal sex behaviors without condoms (insertive with ejaculation, insertive with no ejaculation, receptive with ejaculation and receptive without ejaculation) in the last three months with men other than their main partners.

Sexually Related Substance Use

Sexual activity while using substances was measured with a *yes* or *no* response for the question “have you used this substance while having sex in the last 3 months.” The substances were assessed individually and included alcohol, crystal methamphetamine, ketamine, cocaine/crack, amyl nitrates (‘poppers’), GHB, ecstasy, and marijuana.

Sexual Compulsivity

The sexual compulsivity scale (Kalichman et al., 1994) is a 10-item measure developed from sexual addiction self help literature and has been validated with samples of HIV-positive and HIV-negative men who have sex with men (Benotsch et al., 1999; Kalichman & Rompa,

1995, 2001). Participants were asked to respond to items such as “My sexual appetite has gotten in the way of my relationships” and “I think about sex more than I would like to” using a 4 point likert type scale (1 = *not like me*, 4 = *very much like me*). Internal reliability of the scale for this sample was high ($\alpha = .90$).

Romantic Obsession

The Romantic Obsession scale was developed in a similar manner as the sexual compulsivity measure. Statements from self help literature for “love addicts” and “co-dependents” were listed to create a likert scaled (1 = *strongly disagree*, 5 = *strongly agree*), 10-item measure. The measure includes items such as “I fall in love quickly,” “I obsess about a specific person even though it might be painful”, and “When I meet someone I like, I can’t stop thinking about him.” This measure was previously validated among gay and bisexual men (Missildine, Feldstein, Punzalan, & Parsons, 2005) and demonstrated a high internal consistency ($\alpha = .88$) in the current sample.

Drug/Alcohol Influenced Sexual Expectancies (DAISE)

This scale was developed from qualitative interviews conducted by the investigators in a different study (Parsons et al., 2004) in which a prevalent general theme of expected outcomes in sexual situations while under the influence of alcohol or drugs among men who have sex with men was observed. For these men in their personal experience, drugs and alcohol had led to sexual outcomes that they believed may not have occurred if they had not been under the influence, and most importantly, the men in this study expected similar outcomes in the future when having sex while drinking or using drugs. Therefore, common statements from the men in the previous study were then transposed into scale items such as “I am more sexually aggressive while drinking/high,” “I have sex with people I normally wouldn’t when I am drinking/high” and “I engage in sexual activities I wouldn’t normally do while drinking/getting high (not including sex without condoms/barebacking)” using a likert type 5 point agreement scale. All eight items all loaded on a single factor accounting for 64.40% of the variance and demonstrated an internal consistency of .92 in the present sample. McKirnan, Venable, Ostrow, and Hope (2001) have previously published a scale which is, in essence, conceptually and descriptively similar to this measure.

Peer Norms for Unprotected Sex

Participants were asked to rate how many of their friends they thought engaged in two different risk behaviors (anal receptive sex without a condom and anal insertive sex without a condom) on a scale of 0 (*none*) to 4 (*all*).

Results

Of the 687 men in the sample used for analyses, 82 (12%) identified themselves as a barebacker. These self-identified barebackers also reported significantly higher intentions to engage in unprotected insertive and receptive anal sex; 2.84 vs. 1.36, $F(1, 684) = 212.15$, $P < .01$; 2.52 vs. 1.28, $F(1, 682) = 170.06$, $P < .01$; respectively. HIV-positive men were significantly more likely to identify as a barebacker compared to HIV-negative men, 34% ($n = 31$) vs. 9% ($n = 51$), $\chi^2(1, N = 687) = 47.85$, OR = 5.42, 95% CI: 3.27, 9.11. HIV-positive men were also more likely to report sexually related use of cocaine/crack, 18% ($n = 14$) vs. 7% ($n = 35$), $\chi^2(1, N = 576) = 10.33$, OR = 2.90, 95% CI: 1.48, 5.67; marijuana, 33% ($n = 23$) vs. 18% ($n = 86$), $\chi^2(1, N = 545) = 8.30$, OR = 2.21, 95% CI: 1.28, 3.84; and nitrate inhalants, 37% ($n = 26$) vs. 22% ($n = 102$), $\chi^2(1, N = 543) = 8.21$, OR = 2.15, 95% CI: 1.26, 3.66. HIV-positive men did not differ from HIV-negative men in sexual compulsivity, romantic obsession, or drug/alcohol influenced sexual expectancies. HIV-positive men reported a significantly higher number of substances used with sex in the last three months, 1.85 vs. 1.14, $F(1, 607) = 14.14$, $P < .01$; greater peer norms for unprotected anal insertive sex, 1.49 vs. 1.05, $F(1, 655) = 18.38$, $P < .01$; and greater peer norms for unprotected anal receptive sex, 1.48 vs. .90, $F(1, 653) = 33.97$, $P < .01$. Due to such an array of significant differences across self-reported HIV status, as well as the potential value of understanding differences by HIV status for tailoring of behavioral interventions, the remaining analyses were conducted on the entire sample as well as separately by HIV status. Due to the large number of multiple comparisons and the large sample size, a more conservative test of significance, $P < .01$, was adopted for reporting the following univariate analyses.

As would be expected, men who identified as barebackers reported a higher prevalence of unprotected anal insertive and unprotected anal receptive sexual behaviors regardless of HIV status (Table 1). Barebackers, compared to non-barebackers, reported a higher prevalence of crystal methamphetamine and

Table 1 Bareback Identity and any unprotected sexual behaviors in the past 3 months

Unprotected behavior	Non-BB identity	BB identity	OR	CI
Entire sample				
Anal insertive with ejaculation*	11% (<i>n</i> = 67)	42% (<i>n</i> = 34)	5.54	3.34–9.20
Anal insertive, no ejaculation*	21% (<i>n</i> = 121)	51% (<i>n</i> = 42)	4.06	2.52–6.54
Any anal insertive*	24% (<i>n</i> = 142)	62% (<i>n</i> = 51)	5.21	3.21–8.46
Anal receptive with ejaculation*	7% (<i>n</i> = 40)	29% (<i>n</i> = 24)	5.66	3.19–10.01
Anal receptive, no ejaculation*	14% (<i>n</i> = 82)	40% (<i>n</i> = 33)	4.16	2.53–6.86
Any receptive anal*	16% (<i>n</i> = 91)	45% (<i>n</i> = 37)	4.47	2.74–7.29
Any unprotected anal*	30% (<i>n</i> = 175)	72% (<i>n</i> = 59)	6.07	3.63–10.14
HIV negative				
Anal insertive with ejaculation*	11% (<i>n</i> = 57)	45% (<i>n</i> = 23)	6.83	3.69–12.65
Anal insertive, no ejaculation*	20% (<i>n</i> = 107)	47% (<i>n</i> = 24)	3.51	1.95–6.34
Any anal insertive*	24% (<i>n</i> = 126)	63% (<i>n</i> = 32)	5.43	2.97–9.91
Anal receptive with ejaculation*	6% (<i>n</i> = 33)	29% (<i>n</i> = 15)	6.25	3.11–12.56
Anal receptive, no ejaculation*	13% (<i>n</i> = 71)	33% (<i>n</i> = 17)	3.23	1.72–6.09
Any receptive anal*	15% (<i>n</i> = 78)	41% (<i>n</i> = 21)	4.03	2.20–7.40
Any unprotected anal*	29% (<i>n</i> = 154)	73% (<i>n</i> = 37)	6.44	3.38–12.24
HIV positive				
Anal insertive with ejaculation	17% (<i>n</i> = 10)	36% (<i>n</i> = 11)		
Anal insertive, no ejaculation*	24% (<i>n</i> = 14)	58% (<i>n</i> = 18)	4.45	1.75–11.30
Any anal insertive*	27% (<i>n</i> = 16)	61% (<i>n</i> = 19)	4.35	1.73–10.95
Anal receptive with ejaculation	12% (<i>n</i> = 7)	29% (<i>n</i> = 9)	3.04	1.01–9.19
Anal receptive, no ejaculation*	19% (<i>n</i> = 11)	52% (<i>n</i> = 16)	4.66	1.78–12.18
Any receptive anal*	22% (<i>n</i> = 13)	52% (<i>n</i> = 16)	3.78	1.48–9.62
Any unprotected anal*	35% (<i>n</i> = 21)	71% (<i>n</i> = 22)	4.54	1.77–11.62

**P* < .01

cocaine with sex, when examined separately within HIV status, crystal methamphetamine use remained significant for both HIV negative and HIV positive men (Table 2). Univariate analyses revealed that self-identified barebackers were higher in sexual compulsivity, romantic obsession, drug/alcohol influenced sexual expectancies, number of drugs used with sex in the last 3 months, and all of the peer norms for risk behavior items compared to non-barebackers (Table 3).

When analyses were conducted separately within HIV status, the peer norm items remained significant for both HIV-negative and HIV-positive men. However, different patterns emerged in the univariate findings within HIV status for the other factors. Among HIV negative men, barebackers were significantly higher in sexual compulsivity and romantic obsession, while among HIV-positive men, barebackers were significantly higher in romantic obsession, drug/alcohol influenced sexual expectancies, and the number of substances used with sex.

Logistic regression analyses were then conducted separately by serostatus to control for the independent effect of HIV status, as HIV-positive men were more than five times more likely to self-identify as a barebacker. Variables that differentiated barebackers and non-barebackers in previous analyses were entered into forward conditional analyses in relevant

blocks. Barebacking identity was predicted in the final logistic regression model among HIV-negative men by sexual compulsivity (*P* < .05) and peer norms (*P* < .01) for unprotected anal insertive sex, with 91.4% of cases correctly classified accounting for 14% of the variance. Among HIV-positive men, drug/alcohol influenced sexual expectancies (*P* < .01) and peer norms for unprotected anal receptive sex (*P* < .01) predicted bareback identity, with 85.4% of cases classified correctly accounting for 59% of the variance.

Focusing exclusively within those who identified as barebackers, no differences were observed between HIV-positive and HIV-negative barebackers in the reported prevalence of the four unprotected anal sex behaviors assessed. HIV-positive barebackers were higher in drug/alcohol influenced sexual expectancies, 24.55 vs. 18.71, $F(1, 80) = 8.27$, *P* = .01; number of substances used with sex in the last three months, 2.82 vs. 1.24, $F(1, 75) = 7.84$, *P* = .01; and peer norms for unprotected receptive anal sex, 2.28 vs. 1.64, $F(1, 77) = 7.80$, *P* = .01; compared to HIV-negative barebackers. Lastly, HIV-positive barebackers were 4.7 times more likely to report sex under the influence of alcohol, 76% (*n* = 16) vs. 41% (*n* = 17), $\chi^2 = 7.16$, 95% CI: 1.45, 15.29; and 4.86 times more likely to report sex while using marijuana, 46% (*n* = 10) vs. 14.6% (*n* = 6), $\chi^2 = 7.17$, 95% CI: 1.46, 16.24.

Table 2 Barebacking identity and sexual activity while using substances in the last 3 months

Substances	Non-BB identity	BB identity	OR	CI
Entire sample				
Alcohol (<i>n</i> = 525)	55% (<i>n</i> = 252)	52% (<i>n</i> = 33)		
Crystal meth* (<i>n</i> = 602)	5% (<i>n</i> = 28)	17% (<i>n</i> = 12)	3.59	1.73–7.42
Cocaine/crack* (<i>n</i> = 576)	7% (<i>n</i> = 37)	17% (<i>n</i> = 12)	2.68	1.32–5.43
Ecstasy (<i>n</i> = 574)	9% (<i>n</i> = 44)	15% (<i>n</i> = 11)		
GHB (<i>n</i> = 592)	3% (<i>n</i> = 17)	6% (<i>n</i> = 4)		
Ketamine (<i>n</i> = 583)	4% (<i>n</i> = 19)	9% (<i>n</i> = 6)		
Marijuana (<i>n</i> = 545)	19% (<i>n</i> = 93)	25% (<i>n</i> = 16)		
Nitrate inhalants (<i>n</i> = 543)	23% (<i>n</i> = 109)	30% (<i>n</i> = 19)		
HIV negative				
Alcohol (<i>n</i> = 456)	55% (<i>n</i> = 227)	41% (<i>n</i> = 17)		
Crystal meth (<i>n</i> = 519)**	5% (<i>n</i> = 25)	13% (<i>n</i> = 6)	2.76	1.07–7.14
Cocaine/crack (<i>n</i> = 498)	7% (<i>n</i> = 31)	10% (<i>n</i> = 4)		
Ecstasy (<i>n</i> = 494)	9% (<i>n</i> = 39)	11% (<i>n</i> = 5)		
GHB (<i>n</i> = 509)	3% (<i>n</i> = 14)	2% (<i>n</i> = 1)		
Ketamine (<i>n</i> = 503)	3% (<i>n</i> = 15)	0% (<i>n</i> = 0)		
Marijuana (<i>n</i> = 475)	18% (<i>n</i> = 80)	15% (<i>n</i> = 6)		
Nitrate inhalants (<i>n</i> = 473)	22% (<i>n</i> = 93)	22% (<i>n</i> = 9)		
HIV positive				
Alcohol (<i>n</i> = 69)	52% (<i>n</i> = 25)	76% (<i>n</i> = 16)		
Crystal meth (<i>n</i> = 83)**	5% (<i>n</i> = 3)	22% (<i>n</i> = 6)	5.05	1.16–22.07
Cocaine/crack (<i>n</i> = 78)	12% (<i>n</i> = 6)	30% (<i>n</i> = 8)		
Ecstasy (<i>n</i> = 80)	9% (<i>n</i> = 5)	23% (<i>n</i> = 6)		
GHB (<i>n</i> = 83)	5% (<i>n</i> = 3)	11% (<i>n</i> = 3)		
Ketamine (<i>n</i> = 80)	7% (<i>n</i> = 4)	23% (<i>n</i> = 6)		
Marijuana (<i>n</i> = 70)	27% (<i>n</i> = 13)	46% (<i>n</i> = 10)		
Nitrate inhalants (<i>n</i> = 70)	33% (<i>n</i> = 16)	46% (<i>n</i> = 10)		

P* < .01, *P* < .05

Discussion

These data demonstrate that the barebacking phenomenon is not limited to HIV positive gay and bisexual men. Clearly, the findings of this study indi-

cate that HIV status is an important factor to consider when addressing barebacking among gay and bisexual men. Further, the proportion of HIV positive men identifying as a barebacker in the present study (33.7%) is slightly higher than found in the only other

Table 3 Analysis of variance for bareback identity and psycho-social factors

Factor	Non-BB identity	BB identity	Range	df	<i>F</i>
Entire sample					
Sexual compulsivity*	16.62	19.70	10–40	1, 675	16.64
Romantic obsession*	26.06	29.35	10–50	1, 678	11.74
Drug/alcohol sexual expectancies*	17.28	20.91	8–40	1, 676	15.00
Substances w/sex total*	1.15	1.83	0–9	1, 607	11.59
Peer norms UAI*	.99	1.95	0–4	1, 655	86.68
Peer norms UAR*	.85	1.87	0–4	1, 653	105.94
HIV negative					
Sexual compulsivity*	16.68	20.61	10–40	1, 583	17.21
Romantic obsession*	26.27	29.89	10–50	1, 586	9.46
Drug/alcohol sexual expectancies	17.37	18.71	8–40	1, 584	1.34
Substances w/sex total	1.13	1.24	0–9	1, 521	.204
Peer norms UAI*	.97	1.80	0–4	1, 567	42.14
Peer norms UAR*	.82	1.64	0–4	1, 565	45.08
HIV positive					
Sexual compulsivity	16.16	18.25	10–40	1, 90	2.39
Romantic obsession	24.21	28.45	10–50	1, 90	4.82
Drug/alcohol sexual expectancies*	16.49	25.55	8–40	1, 90	20.02
Substances w/sex total*	1.35	2.82	0–9	1, 84	8.31
Peer norms UAI*	1.14	2.21	0–4	1, 86	32.16
Peer norms UAR*	1.08	2.28	0–4	1, 86	42.09

**P* < .01

study to ask this question directly (27.2% in Halkitis et al., 2005). Regardless of HIV status, the findings of this study indicate many differences between self-identified barebackers and other gay and bisexual men that may potentially inform outreach efforts to current barebackers and campaigns to prevent men from becoming barebackers who seek unprotected sex with casual partners.

Of particular concern is the link observed between the use of crystal methamphetamine and bareback identity. Due to the potential for spurious comparisons, this finding should be viewed with caution, however, this finding is supported in part by the numerous reports of crystal methamphetamine and unprotected anal sex among gay and bisexual men (Colfax et al., 2005; Halkitis et al., 2001, 2003; Kurtz, 2005; Nanin & Parsons, 2006; Purcell et al., 2005). Methamphetamine has recently been linked to increases in HIV infection, due to the relationship between this drug and unprotected sex. However, it may be that barebacking identity is the common factor, driving both the use of methamphetamine as well as the condomless sex.

Barebackers in this sample were also higher in drug and alcohol related sexual expectancies. McKirnan et al. (2001) suggest that gay and bisexual men expect to benefit sexually from the cognitively disengaging effects of alcohol and substance use, which could lead barebacking men to the use of methamphetamine (as well as other drugs). Clearly, the role of drug and alcohol use related sexual expectancies among HIV positive gay and bisexual men warrants further investigation. Moreover, barebackers in this sample were significantly higher in sexual compulsivity and romantic obsession, these issues may be points of intervention for mental health workers to explore with clients.

Existing interventions targeting sexual risk behavior are often aimed at highly motivated individuals who consent to participate. Gay and bisexual men who identify as barebackers may not be interested in such intervention efforts. As such, novel intervention approaches which can be utilized with gay and bisexual men who bareback, as well as other risk taking persons, are urgently needed if we expect to decrease rates of HIV infection. Brief interventions that incorporate a counseling style that is client-centered, and non-judgmental, such as Motivational Interviewing (Miller & Rollnick, 2002), may hold great promise for working with gay and bisexual men who engage in barebacking. (For a detailed outline of using this approach with barebackers, please see Parsons, 2005b). Another approach may be targeting the connection between substance use and sexual behaviors. Shoptaw and Frosch (2000) have suggested that substance abuse

treatment functions as HIV prevention among gay men and as indicated by our findings with crystal methamphetamine and specifically with drug and alcohol influenced sexual expectancies among HIV-positive men, once these areas are addressed the barebacking issue may be resolved in the process.

Community wide prevention efforts could also target perceived peer norms for barebacking by challenging beliefs about the prevalence of barebacking in the gay community. However, Rogers and Shefner-Rodgers (1999) have warned that HIV prevention efforts must be consistent with existing community values. Given the open debates about barebacking, this warning must be heeded if effective programs and campaigns are to be developed for gay men. Future research is clearly needed to identify what values are important to gay men, followed by developing public health campaigns targeting barebacking utilizing those values.

Specifically, there will be men who are firmly entrenched in their decision to forgo condoms and to continue barebacking. In addition, Gerrard, Gibbons, and Bushman, (1996) have suggested that behavior determines an individual's perception of vulnerability to HIV infection (or transmission) rather than the perception of vulnerability leading influencing behavior (Bancroft, 2000). Recent research supports this premise. Gay and bisexual men, regardless of HIV status, have reported adopting sexual harm reduction strategies (Wolitski, 2005) such as *strategic positioning* (Parsons et al., 2005; Van de Ven et al., 2002), the practice of engaging in the type of unprotected anal sex believed to be the least likely to result in HIV transmission (e.g., HIV-negative men as the insertive partner; HIV-positive as the receptive partner). Another prevalent strategy is *serosorting*—limiting sexual contact to men of the same (real or perceived) HIV status (Cox, Beauchemin, & Allard, 2004; Parsons et al., 2005). For men who will continue barebacking in casual encounters, encouraging serosorting and strategic positioning may be the most appropriate course of action. The flaws in this approach for HIV-negative men are apparent; current testing technology for HIV status involves a “window period” during which a false negative result is quite possible. In addition lubricants with microbicides (Tabet et al., 2003) for use in anal sex could be a beneficial alternative to condom use for men who continue engage in barebacking. Several studies have indicated that the majority of gay HIV negative men reported a willingness to use rectal microbicide (Carballo-Diequez et al., 2000; Gross, Buchbinder, Celum, Heagerty, & Seage, 1998; Marks et al., 2000; Rader et al., 2001).

Pre-bareback era research may provide some insight to the findings of this study as well as the emergence of barebacking in the gay community. In the first decade of the HIV epidemic, Joseph, Adib, Joseph, and Tal (1991) reported that gay identity and successful integration into a gay social network played a role in reducing sexual risk taking among gay men. Similarly, Ridge, Plummer, and Minichiello (1994) proposed that for young gay men in their sample, sexual safety was a social process; young men who socialized within gay communities were more likely to practice safer sex by adopting prevalent peer norms for safer sex. Morton and Duck (2000) reported a clear relationship between strong identification with the gay community, frequency of gay-related media use, and higher positive attitudes toward safer sex supporting earlier findings by Seibt and Ross (1995). Identity and affiliation appeared to play a role in adopting safer sex practices before barebacking emerged among gay and bisexual men. It seems that in less than a decade, gay men went from reporting peer pressure for condom use to feeling pressured by peers to bareback (Morin et al., 2003). Websites devoted to barebacking have proliferated (Gauthier & Forsyth, 1999; Grov, 2004; Tewksbury, 2003) and thus it appears the relationship between sexual risk and social factors that promoted safer sex in the first 15 years of the HIV epidemic has reversed. The current social climate of the gay community may be facilitating and sustaining barebacking behaviors and the development of a barebacker identity.

Gatter (1995) contends that identity is a cultural product emerging from specific cultural and historical circumstances as is clearly the case with barebacking. For example, Fordham and Ogbu (1986) proposed that African-American youth develop an *oppositional identity* in contrast to characteristics and behaviors associated with Whites. The authors argue that African-Americans youth develop an oppositional identity in response to criticisms of “acting too white” or “not being black enough” by their peers (Fordham & Ogbu, 1986). Crossley (2004) offers similar insights into gay men arguing that resistance has been a consistent feature of gay men’s psyche since the beginning of gay liberation. This resistance extends toward all “restricting” cultural mores. Barebackers may feel disenfranchised from the larger culture as well as gay community due to HIV phobia and discrimination (Cadwell, 1991; Stirratt, 2005), exalted standards of beauty (Beren, Hayden, Wilfley, & Grilo, 1996; Siever, 1994; Wood, 2004) and materialism (Clark, 1993).

Further research is clearly warranted to investigate the development of a bareback identity. Specifically, the validity of barebacking as an oppositional identity

could be explored employing qualitative methods as well as quantitative surveys with relevant measures such as attachment to and perceptions of the gay community. Factors such as serosorting, strategic positioning, and partner familiarity should also be addressed. Lastly, many studies of condom use have employed theoretical models, none as of yet have appeared that investigated barebacking in a theoretical framework (Carballo-Diequez & Bauermeister, 2004).

Some factors should be taken into consideration when evaluating the results of this study. Familiarity with the partners (anonymous versus repeat casual partner, etc.) was not assessed and the measurement of sexual risk behaviors used for the present study did not distinguish between HIV seroconcordant and serodiscordant casual partners. Further, it was beyond the scope of this study to ascertain what meanings participants attached to barebacking, e.g., intentional unprotected sex. Unfortunately, extensive pilot testing of measures or debriefing participants, which are costly endeavors, were beyond the tight budget constraints of this exploratory survey. Additionally, the settings where this data were collected may limit the generalizability of these findings to gay and bisexual men comfortable attending such events. Some individuals might have been reluctant to attend these events due to conflicts over sexual orientation, internalized homophobia, or lack of interest and/or attachment to the gay community. Lastly, the survey was administered in a public venue, participants may have been reluctant to respond truthfully to sensitive questions about their sexual behaviors and substance use. However, such events are suitable places for HIV prevention outreach efforts, thus this study is ecologically valid. The potential target population was sampled in the same venues in which interventions and public media campaigns could be implemented.

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